health, health care and medicare

a report by the
national council of welfare

autumn 1990

Canada

HEALTH, HEALTH CARE AND MEDICARE

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National Council of Welfare

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FOREWORD

One of the unfortunate realities in the world of health is the wide gap between the opinions of the experts who study our health care system and the views of ordinary Canadians.

The experts say we have more doctors than we need. The general public believes we have too few. The experts think we have enough hospital beds. The public wants more. The experts have their doubts about some of the latest medical technology. The public seems completely uncritical and wants all it can get immediately.

Most fundamentally, the experts believe that curative medicine is reaching its limits and that more substantial gains in health will come through preventing illness. The public still seems preoccupied with disease and clings to its faith in miracle cures.

This report is an attempt to bridge these gaps.

INTRODUCTION

In May 1982, the National Council of Welfare issued its first report on health care, Medicare: The Public Good and Private Practice. The report reviewed the latest available Canadian research on the higher risks of illness and premature death facing poor people. It traced the history of public health insurance in Canada. And it set forth a prescription for medicare that turned out to be similar to the prescription adopted by Parliament in the Canada Health Act of 1984.

This report is partly an update of that earlier work, but it takes the Council into new areas as well. Its title Health, Health Care and Medicare was chosen specifically to remind readers of differences among these three terms which are often ignored. "Health" refers to a state of physical and mental well-being, not merely the absence of disease. "Health care" refers to an industry that provides a range of services and goods which may or may not be covered by government-run health care plans. For example, the cost of medications and routine dental care is normally paid by individuals or private insurance plans. "Medicare" refers only to those medical and hospital services which are covered by provincial or territorial public health insurance plans.

This report seeks to shed further light on each of these three general areas. Many of the issues that we raise are not new to experts in the field. They have been discussed for years in medical and scientific circles, but they have yet to have much impact on the thinking of most Canadians.

We begin by taking the broadest view and asking the toughest questions. Why do poor people live shorter and less healthy lives

than rich people? What are the obstacles that stand in the way of better health for native people? Can we convince governments that many of the things done outside Health Departments have a significant impact on the health of Canadians?

In the chapters that follow, we narrow our focus to ways of improving the health care system. Most of the changes during the last generation involved financial arrangements for health care rather than the way the system is organized. Basically what happened was that governments stepped in and started paying doctors and hospitals directly for their services to patients. Issues such as getting the most out of medical technology were too often shunted aside.

The final chapters narrow the focus even more to issues related to medicare in the aftermath of the Canada Health Act. We discuss problems that have arisen; we restate the strong case we made in 1982 against medicare premiums; and we urge governments to redouble their efforts in the field of long-term or extended health care.

Throughout this report, we call for more federal leadership in health, in health care and in medicare. This should come as no surprise, given our mandate as advisers to the Minister of National Health and Welfare. But there are more substantive reasons for our interest in seeing the federal government use its considerable influence.

First and foremost is our belief that the Canadian health care system and the promotion of better health among Canadians require nation-wide initiatives. These initiatives will occur only if the federal government exercises active leadership.

Although the delivery of health care services is a matter of provincial jurisdiction under the Constitution, the fact is that the federal government has long played a major role in health care by virtue of its "spending power."

The leverage behind federal spending was directly responsible for the creation of medicare as we know it today. It was federal legislation that set the standards for medicare and federal money that made it possible for all provinces and territories to create medicare programs of their own within a national framework.

Conversely, it is long-term care for the elderly and chronically ill which has a much smaller federal presence and which is much less developed. Given regional disparities and the inability of smaller provinces to undertake major new programs on their own, we believe strong federal leadership and extensive federal funding are vital to the development of a system of publicly insured nursing homes and home care services that extends from coast to coast.

A second reason for a national perspective relates to the mobility of Canadians. People who move from one province to another have the right to expect services and opportunities that are more or less comparable everywhere. People who grew up in Manitoba, for example, and paid taxes most of their lives to support a provincial medicare program that provides insured nursing home care should be able to take advantage of a comparable program if they retire in British Columbia.

A third reason is that many of the problems and challenges in the field of health transcend the boundaries of any one province or territory. It makes no sense for each province

and territory to set up panels of experts to assess the latest medical technology or to conduct the same pilot projects in hopes of improving their individual medicare systems.

All this does not mean that the provinces and territories should be minor players in the development of our health care system. They are responsible for the day-to-day operations of medicare, so their expertise, their advice, and their huge financial commitments are indispensible. It is clear from the number of commissions and inquiries into health that have been launched by provincial governments in recent years that they are taking their responsibilities seriously.

The question in our minds is to what extent provinces and territories are willing to look beyond their own boundaries and co-operate with each other, and with the federal government, in initiatives which are clearly in the best interest of all Canadians. Co-operation has been a rare commodity in recent years, and there seem to be more examples of failure than success.

Even a sensible and straightforward project like developing standardized definitions for different types of extended health care services has so far proved to be an insurmountable challenge. A federal-provincial working group undertook the task in 1972, but to this day, little progress has been made. The terms in current use still vary greatly from province to province and are often confusing, misleading or unintelligible to ordinary people.

Larger provinces, particularly Quebec and Ontario, have the capacity to undertake major new initiatives in health care on their own, but it would be most unfortunate if they left the

smaller provinces behind. The end result would be a system that varied enormously from province to province, where access to certain forms of insured care depended primarily on a person's place of residence.

Such a patchwork system would be a giant step backward from the ideal of a comprehensive, nation-wide system of public health insurance advanced by the founders of medicare and embraced by the vast majority of Canadians.

1. THE HEALTH GAP

One of the saddest facts of Canadian life is the health gap that separates rich and poor. Simply put, well-off Canadians live longer and healthier lives on average than low-income Canadians. The reasons for the gap are not fully understood, but they appear to be due in large part to the debilitating conditions of life that poverty forces upon people.

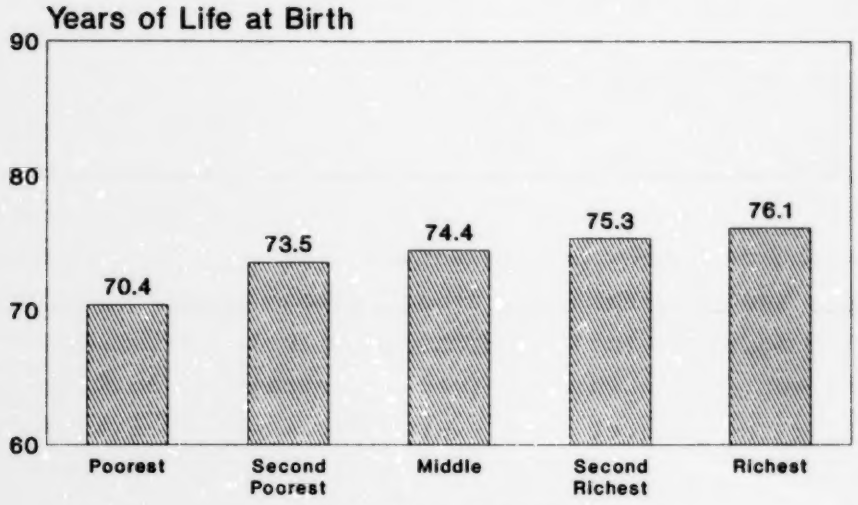
The health gap can be measured by two types of standards. Most often, it is expressed in terms of death rates or average life expectancies for people in different income groups. It can also be expressed as "health expectancies" that compare degrees of health among people in different income groups. Either way, the results are similar.

In terms of death rates, the latest available information shows that Canada's health gap got smaller between 1971 and 1986, but the difference between rich and poor remained pronounced, especially among men.[1]

Researchers at Statistics Canada and Health and Welfare Canada studied deaths in major cities among residents of different types of neighborhoods in 1971 and 1986. The neighborhoods were divided into five groups and ranked according to the percentage of low-income people in each.[2]

Both studies found that the poorer the neighborhood, the shorter the average life expectancy of residents. The results for 1986 are shown on the next page in Figure A.

Life Expectancy of Males By Neighborhood Income, 1986



Life Expectancy of Females By Neighborhood Income, 1986

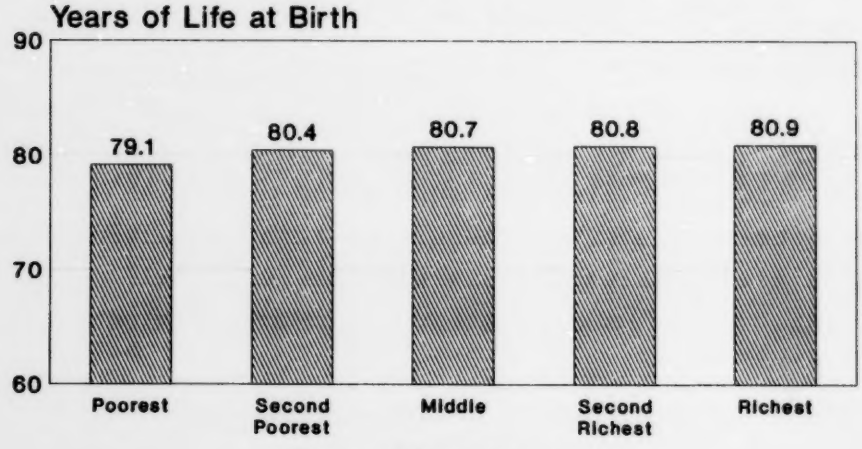


Figure A

Men in the poorest neighborhoods lived 70.4 years on average, and men in the richest neighborhoods lived an average of 76.1 years, so the health gap was 5.7 years. For women, average life spans ranged from 79.1 years to 80.9 years, and the health gap was 1.8 years.

The health gaps were smaller for both men and women in 1986 than in 1971, but the same general patterns prevailed. In the 1971 study, men from the poorest neighborhoods lived an average of 67.1 years and men from the richest neighborhoods lived an average of 73.4 years, for a health gap of 6.3 years. Women from the poorest neighborhoods lived an average of 76.9 years and women from the richest 79.7 years, for a gap of 2.8 years.

The link between income and death also appears in infant mortality rates found in the two studies, as Table 1 shows.

TABLE 1

INFANT DEATHS PER THOUSAND BIRTHS IN URBAN CANADA, BY NEIGHBORHOOD INCOME

	1971	1986
Poorest neighborhoods	20.0	10.5
Second poorest	16.6	8.0
Middle	15.2	7.7
Second richest	12.4	5.7
Richest neighborhoods	10.2	5.8
ALL NEIGHBORHOODS	15.0	7.5

Infant mortality rates came down sharply between 1971 and 1986 - both the overall rate for urban Canada and the rates for each type of neighborhood. But babies born to parents in the poorest neighborhoods were still twice as likely to die before their first birthday as babies born to parents in the richest neighborhoods.

More recent information about the health gap came in a study by Statistics Canada and the Canadian Institute for Advanced Research. It related deaths to individual earnings over a period of years among men 65 and older who had contributed to the Canada Pension Plan.[3]

The death rates for men between the ages of 65 and 70 declined steadily as the level of earnings in the years prior to retirement increased. The death rates at the lower end of the income scale were about twice as high as the rates at the upper end of the scale.

The study corroborates the conclusions of earlier studies and is especially important because it was based on individual rather than neighborhood income, because the income data covered earnings over many years, and because the sample size was huge and highly representative.

"It is difficult to imagine a clearer and more unequivocal result," the researchers concluded. "These data cover over half a million individuals, and for each individual data from almost a quarter century of their lives have been drawn upon."

Just as all of these studies and research in other countries show a strong link between life expectancy and income, there are

studies of health expectancy showing that poor people bear a disproportionate amount of ill health and disability.

"It is clear that people of lower-income groups and with lower levels of education do not enjoy the same level of health as those Canadians of higher social and economic status," said the report on the Canada Health Survey of 1978.[4]

Table 2 is based on a further study of the survey data. It shows the total life expectancy of people in different income groups in 1978 and the number of years spent in each state of health.[5]

TABLE 2

YEARS OF LIFE, BY HEALTH STATUS AND INCOME, 1978

	Income Group				
State of Health	Lowest	Second Lowest	Middle	Second Highest	Highest
Not restricted in activities	54.9	59.9	62.7	63.1	65.9
Short-term disabilities	1.4	1.4	1.4	1.3	1.5
Minor activity restriction	1.5	1.7	1.4	1.8	3.0
Restricted in major activity	8.7	7.7	7.5	8.0	5.2
Cannot do major activity	5.4	3.2	1.7	1.3	0.8
TOTAL LIFE EXPECTANCY	71.9	73.8	74.7	75.5	76.4

On average, Canadians in the lowest income group had 54.9 years of life in good health without restrictions on their activities. The number of years of good health increased steadily by income group and reached 65.9 years of good health for the highest income group. In other words, the gap between high-income and low-income people was 11 years of good health.

Conversely, low-income people had more years of ill health than high-income people. For example, people in the lowest group spent an average of 5.4 years unable to do major activities. The comparable figure for those in the highest group was 0.8 years.

Figures tabulated by sex showed that men in the lowest income group had 50 years on average without restrictions on their activities while men in the highest income group had 64.3 years of good health, a difference of 14.3 years. Women in the lowest income group had 59.9 years without activity restrictions and women in the highest group 67.5 years, a gap of 7.6 years.

"Obviously, between rich and poor in Canada, there is no trade-off between life expectancy and activity restriction," the researchers concluded. "A shorter life is not compensated for by less disability."

Information collected by Statistics Canada and Health and Welfare Canada shows striking differences as well in the health of young people based on family incomes.

As Russell Wilkins of the Canadian Centre for Health Information at Statistics Canada told a Parliamentary subcommittee studying child poverty in 1990: "Based on the best data currently available for Canada, it appears that the health problems of poor children begin before birth and continue to place these children

at greater risk of death, disability and other health problems throughout infancy, childhood and adolescence."[6]

Low birth weight - babies weighing less than 2,500 grams at birth - is a major risk factor for infant mortality and disability. The average rate of low birth weight in 1986 was seven percent in the poorest urban neighborhoods and only five percent in the richest.

Teenage girls face a higher risk of having babies of low birth weight than older women, regardless of income. However, the birth rate among teenage mothers is about four times higher in the poorest urban neighborhoods than it is in the richest.

Finally, recent studies show a strong relationship between income and disability in children under the age of 15. Looking at children who were living at home in 1986, seven percent of the children from families with the lowest incomes were disabled, compared to 3.5 percent of the children from families with the highest incomes. The gap was even wider when only severe disabilities were considered.

While the results of these and other studies are clear and consistent, the reasons for the health gap are still being sought. Studies of income and mortality which have adjusted for all known risk factors have found there remains a large and unexplained gap between rich and poor.

In a study in Alameda County, California, researchers found that people with inadequate family incomes had 2.1 times the risk of death of those with high incomes. After the data were adjusted for age, sex, race, smoking, alcohol consumption, sleep habits, physical activity, weight, blood pressure, and the presence of

heart trouble, chest pain, diabetes or cancer, people in the low-income group still faced 1.6 times the risk of death as those in the high-income group.[7]

International comparisons among developed countries show that mortality is strongly correlated to income distribution and not to any fixed amount of income. A study covering the 11 member countries of the Organization for Economic Co-operation and Development showed that people in countries with more equal income distributions had higher life expectancies.[8]

Sweden, Norway and The Netherlands had the most equal income distributions and the highest life expectancies overall. The United States, where great wealth and great poverty both abound, had the second lowest overall life expectancy. Canada was near the middle on both counts.

The health gap was officially recognized by the Canadian government in a 1986 publication by Health and Welfare Canada entitled Achieving Health for All: A Framework for Health Promotion.

"The first challenge we face is to find ways of reducing inequities in the health of low- versus high-income groups in Canada," the paper said. "As we search for health policies which can take this country confidently into the future, it is obvious that the reduction of health inequities between high- and low-income groups is one of our leading challenges."[9]

Since 1986, however, the government has not taken two basic steps that flow naturally from its general commitment to reducing the health gap: allocating more money for research on the problem and collecting additional data.

Almost every national organization in the health care field has called for regular surveys of the health status of Canadians. These include the Canadian Hospital Association, the Canadian Medical Association, the Canadian Nurses Association and the Canadian Public Health Association.

The Canada Health Survey was meant to be an annual survey, but it was discontinued after only one year because of federal government spending restraints. It should be revived and conducted on a regular basis.

It is all the more urgent that the federal government act quickly now that Quebec has initiated its own health survey and Ontario is in the process of doing so. Aside from the inefficiency of having each province act individually, separate initiatives could make it more difficult to get reliable data on a national basis. As Quebec and Ontario build up storehouses of data over the years, they would be increasingly reluctant to change their surveys to fit national needs. Poorer provinces which cannot afford to do surveys on their own would find themselves left out altogether.

Recommendation #1. The federal government should resume regular surveys of the health status of Canadians with a particular view to understanding the health gap that separates rich and poor.

Recommendation #2. The federal government should devote more resources both inside and outside government to research on the reasons for the health gap and strategies for reducing it.

2. THE HEALTH OF ABORIGINAL PEOPLE

When we talk of the health gap and the extraordinary health problems facing poor Canadians, one disadvantaged group that immediately comes to mind is aboriginal people. Study after study has shown the excessive danger to life and limb facing status Indians living on reserves, not to mention native people living elsewhere.

The most recent federal government figures show there are more than half a million status Indians in Canada, roughly 60 percent of them living on reserves. The government says the number of Metis and non-status Indians is close to 400,000, although some groups believe that estimate is far too low. There are also about 33,000 Inuit, mostly in the Northwest Territories.[10]

While there have been significant improvements in some areas of native health in recent years, the overall picture remains depressing. For status Indians living on reserves, the estimated average life expectancy at birth in 1991 will be 65.7 years for men and 73 years for women. The comparable estimates for the population as a whole are 74.1 years for men and 81.2 years for women.[11]

The infant mortality rate for children up to 12 months old was 17.2 deaths per thousand live births in 1986 for status Indians, more than twice the Canadian average of 7.9 deaths per thousand. Most of the difference occurred in the post-neonatal period, the period from one month to 12 months.[12]

The persistence of high post-neonatal death rates suggests that too many babies are falling victim to the general conditions responsible for poor health on reserves. Once they go home from hospital after birth, they are exposed to health risks that are much higher than normal.

A recent study by the Canadian Institute of Child Health described the health of aboriginal people this way:[13]

> The pattern of disease among Canada's native people resembles the main killers of the developing world. Infections and parasitic and respiratory diseases, often helped by malnutrition, account for most deaths under one year of age. Accompanying these are "diseases" of economic under-development. Many native people live in poverty and, consequently, when combined with the implicit and explicit racism of our society, they are doubly oppressed. The state of poverty in which they live makes them particularly vulnerable to health hazards.

Native people are much more likely to die from accidents or violence than other Canadians. These two causes accounted for nearly one of every three deaths among status Indians on reserves from 1978 to 1986. Accidental deaths were particularly high among men. Suicide rates averaged 34 per 100,000 between 1983 and 1986, compared to the national average of 14 per 100,000.[14]

For aboriginal people living away from reserves, there is very little information on death rates or health problems. A 1971 study of Indians living off reserve in British Columbia found that the rate of hospitalization for those aged 15 to 60 was about 3 1/2 times that of other British Columbians.[15] Most people involved in health services for urban natives believe that their rates of death

and illness are similar or even more pronounced than the rates found on reserves.

A significant number of native people living in urban areas are members of single-parent families. In Winnipeg, for example, about one-third of all native families in 1981 were single-parent families, the vast majority of them headed by women.[16]

Aboriginal people living in cities are often unable to find decent jobs, and they face the added problems of discrimination, culture shock and separation from their extended families. None of these conditions is conducive to good health.

Improving the health of aboriginal people should clearly be a national priority. Unfortunately, jurisdictional differences between Ottawa and the provinces and territories are getting in the way of solutions to this problem.

Under the Constitution, the federal government is responsible for Indians and lands reserved for Indians. In practice, that means Ottawa accepts responsibility for health services to Indians on reserves and in the two territories. Services are delivered by the medical services branch of Health and Welfare Canada or through purchase-of-service agreements.

As part of the movement towards self-government, some reserves have taken over responsibility for their own health services. Nevertheless, the federal government remains the source of funding for these services and retains ultimate constitutional responsibility.

The situation is not clear for aboriginal people living off the reserve. By and large, native people and the provinces

believe that the federal government has responsibility for services off reserve. The federal government disagrees.

The National Council of Welfare hopes the two levels of government will somehow find a way to put an end to this dispute as soon as possible. It is unreasonable for jurisdiction to stand in the way of addressing one of Canada's most serious health problems. An early meeting of federal, provincial and territorial Ministers of Health might provide a useful forum for addressing the problem.

We have no easy answers to the jurisdictional question and no magic formulas for improving the health of native Canadians. However, we do believe that many of the pathways to better health must be found outside of the health care system. There may be little that medical intervention can do to improve native health status unless the underlying contributory factors of their daily environment are addressed.

Many native people live in conditions like those in the Third World, conditions which few non-native Canadians have experienced in decades. Many reserves still lack clean, safe drinking water, and many do not have adequate sewage treatment facilities.[17]

Water and sewage treatment led to dramatic improvements in the health of vast numbers of Canadians during the early part of this century. We believe it can do the same for native people, and we urge governments to make sure there is ample funding available.

As we mentioned earlier, negotiations are under way with many Indian bands to transfer medical services to the bands as part of the movement towards self-government. But since many existing

services are inadequate, a simple transfer is not enough. There has to be a substantial increase in funding at the same time.

Finally, at least part of the poor health status of aboriginal people is linked to their low incomes and all the other burdens that go hand in hand with poverty. Part of the solution must be better income security programs, more jobs, enhanced educational opportunities, and a wider range of social services.

The National Council of Welfare believes that aboriginal people themselves must play a central role in all these areas. It is crucial that they have the opportunity to plan, implement and evaluate the programs they find most relevant to their own communities.

Recommendation #3. The National Council of Welfare urges governments and organizations representing native people to negotiate a solution to the long-standing jurisdictional disputes involving aboriginal people living off reserves.

Recommendation #4. The federal government should ensure adequate levels of funding for projects on Indian reserves to enhance the health and well-being of residents. Among other things, there should be guarantees of modern water and waste disposal systems and a wide range of health and social services.

3. NATIONAL HEALTH OBJECTIVES

Virtually all national groups in the health care field and Ministers of Health at both the federal and provincial levels of government accept the notion of health objectives. Having objectives helps governments set priorities, raises public awareness of health issues, and makes it possible to measure how far Canada has gone on the road to "better health for all."

Health objectives are already an established feature of public policy in the United States. The U.S. Department of Health and Human Services published 226 objectives in 1980. This was followed in 1986 with objectives for the 'nineties and a review of progress to date. Work is now under way on objectives for the year 2000.[18]

The original American objectives covered 15 different areas: high blood pressure, family planning, pregnancy and infant health, immunization, sexually transmitted diseases, control of toxic agents, occupational safety and health, accident prevention and injury control, fluoridation and dental health, surveillance and control of infectious diseases, smoking, misuse of alcohol and drugs, nutrition, physical fitness and exercise, and control of stress and violent behavior.

There were specific targets in each of these areas. Take, for example, high blood pressure, a leading risk factor for heart disease that often goes undetected. Among the objectives for 1990 were the following:[19]

* At least 90 percent of adults should be able to state whether their blood pressure is normal or elevated.

* No area of the United States should be without an effective public program to identify people with high blood pressure and to follow up on their treatment.

* Use of sodium by adults should be reduced to between three and six grams daily.

* At least 60 percent of the estimated population with high blood pressure should have had it brought under control for a period of at least two years.

One of the qualities that makes these objectives noteworthy is their detail. Instead of settling for a general "motherhood" call against high blood pressure, American planners set down specific goals that could be easily measured.

The scope of the objectives is also worth noting. It includes better individual awareness of the problem of high blood pressure, more extensive public health programs, the reduction of risk by getting people to eat less salt and, finally, the actual control of blood pressure.

In general, Canada has lagged well behind the United States in the area of health objectives. Both Quebec and Ontario have been working on objectives for a number of years, but neither province has matched the detail of the U.S. objectives.

Neither the 1984 Quebec publication Objectif: santé nor the 1987 report Health for All Ontario gets beyond generalities. The section in the Quebec report on cancer calls for restricting the use of tobacco, increasing the amount of fruit and vegetables in the diet, reducing the amount of fat, and promoting early detection of breast cancer and cervical cancer.[20] The section

in the Ontario report on alcohol never gets beyond the general observations that the price of alcohol should be kept high to discourage consumption and there should be programs in each community to help people at risk.[21]

In both cases, the goals are well-meaning, but the advice is not specific enough, and there is no precise way of determining how well the goals are being met.

A much better Canadian example is found in the National Program to Reduce Smoking, a co-operative venture involving both governments and outside groups. One of the many specific objectives of the program was to convince 80 percent of Canadians by 1990 that smoking should not be permitted in public places unless expressly allowed. Another is to reduce by 30 percent the number of young people aged 12 to 19 who take up smoking by the year 2000.[22]

These and the other objectives of the program are more like the U.S. health objectives because they point toward specific targets. If the targets are met within the specified time frame, so much the better. If not, the people involved in the program will have to try to find out what went wrong and deal with their failures.

How should health objectives be set in Canada? In our view, that is a job that should be left to a new institution that might be called the Canadian Health Council. The council would set health objectives after consulting the public at large, and it would work to keep health in general, and health objectives in particular, in the public eye.

Since health is a concern of all Canadians, we believe that a health council should include people from both inside and outside government and lay people as well as experts. Perhaps some of its members could be named by the federal, provincial and territorial governments and others by groups with special interest in health. Among the groups that would be worth approaching are: the Canadian Public Health Association, the Canadian Nurses Association, the Canadian Hospital Association, the Canadian Medical Association, the Royal College of Physicians and Surgeons, the College of Family Physicians and the Association of Canadian Medical Colleges.

The council could have a small permanent staff to do research, publish reports, and act as advocates for our health objectives. A small staff with a small budget located within Health and Welfare Canada, but at arm's length from the Department, is one possible arrangement.

A health council would be a valuable addition to the Canadian landscape. It would give ordinary Canadians a second opinion on the state of their health. And it would remind governments and health care professionals of the broader view of what health is all about.

Recommendation #5. The National Council of Welfare proposes the creation of a Canadian Health Council to set health objectives and monitor progress in meeting those objectives. The new council should be made up of people named by governments, the health care professions, and other groups with a special interest in health.

4. HEALTHY PUBLIC POLICY

One of the more promising approaches to improving the health of Canadians is "healthy public policy." Used in its broadest sense, the phrase means that governments should consider the health consequences of all their policies, not just policies made by Ministers of Health.

As early as 1974, the federal government recognized that good health involves more than doctors and hospitals. As its landmark publication A New Perspective on the Health of Canadians put it, "Marvellous though health care services are in Canada in comparison with many other countries, there is little doubt that future improvements in the level of health of Canadians lie mainly in improving the environment, moderating self-imposed risks and adding to our knowledge of human biology."[23]

Healthy public policy is part of this same perspective. It could be used to describe government decisions to require the use of seat belts in motor vehicles or crack-downs on impaired driving. It could also apply to cleaning up the environment, improving safety in the workplace and providing better social services to people in need.

The federal government emphasized the importance of healthy public policy in its 1986 paper Achieving Health for All. It also recognized the difficulty of putting the policy into practice, given the fact that the priorities of one department or agency of government rarely coincide with the priorities of others.[24]

One possible way of dealing with differing priorities would be to require a health impact assessment for certain programs or

projects, just as an environmental impact assessment is now required for certain projects. Such a requirement would force other departments and agencies to consider the effects of their proposals on the health of Canadians. As well, ordinary Canadians and special interest groups would be able to use a health impact statement to assess the consequences of a particular program or project and to lobby for improvements.

In this chapter, we give two examples of the application of healthy public policy, one obvious and one not so obvious. First, we return to the health gap that separates rich and poor and restate arguments we made over the years for policies to fight poverty in Canada. Then we turn to an obvious application of healthy public policy: preventing unwanted pregnancies and sexually transmitted diseases among teenagers.

From its beginning in 1970, the National Council of Welfare took a wide-ranging view of poverty and its effects. Two early Council reports made explicit links between poverty among children and health. A 1973 report <u>One Child, One Chance</u> examined the nutritional problems of low-income families and their impact on health and development. A 1975 report entitled <u>Poor Kids</u> documented the effects of poverty on their physical, mental and social development - effects which may not be reversible later in life.

The same themes were part of the landmark report of the Ontario Social Assistance Review Committee published in 1988 under the title <u>Transitions</u>. Like the National Council of Welfare, the committee viewed many of its recommendations for welfare reform as health recommendations. In its words, "Implementation of our proposals with respect to the adequacy of social assistance benefits, new income security programs, housing, employment and

other opportunities for self-reliance will also improve the health of the poor."[25]

Second Opinion, a critique of our health care system by Dr. Michael Rachlis and Carol Kushner published in 1989, went even further. The authors proposed reallocating $12 billion a year in health care spending, with about half of the total going directly into social policy initiatives for disadvantaged Canadians.

The package would include additional financial help of up to $1,000 a year for people on government assistance programs and the working poor, more social housing, more funds for literacy programs, 750 new transition houses for battered women and their children, and economic development programs for women and aboriginal people.[26]

The proposals of Rachlis and Kushner might be seen as the ultimate in healthy public policy, and they obviously are too radical for many people. However, that should not discourage governments from making smaller advances.

As a case in point, we were struck by research on pregnancy and sexually transmitted diseases among teenagers in Alberta.[27] It is difficult to imagine a better description of healthy public policy than programs which would prevent these problems.

Alberta teens are more likely to get pregnant than teens in most other parts of Canada. They face higher-than-normal risks of sexually transmitted diseases and pelvic inflammatory disease, and of ectopic pregnancy and infertility related to these diseases. These problems seem to be linked directly to the haphazard use of condoms and other barrier methods of contraception, delays in seeking treatment for sexually

transmitted diseases and, until recently, the lack of a comprehensive sex education program in Alberta schools.

As we noted in Chapter 1, babies born to teen mothers are much more likely to be of low birth weight, and babies of low birth weight have a much higher risk of death or serious illness than babies of normal weight.

Teen mothers are much more likely to have to cope on their own. They have difficulty finding decent jobs and an inordinately high risk of winding up on welfare. The cost of supporting Alberta single-parent families created by first births to teenage mothers during 1985 alone has been estimated at $444 million over a period of 20 years.

The conclusions that arise from this research should be obvious. The failure of governments and health care professionals to address the problems related to the sexual mores of young people is having far-reaching consequences on health and the health care system as well as on the cost of welfare and social services. Application of the principles of healthy public policy would provide low-cost solutions to these high-cost problems.

Recommendation #6. The National Council of Welfare endorses the concept of "healthy public policy" and urges all governments to make it standard practice in their policy-making. They should also consider requiring health impact assessments in much the same way that they now require environmental impact assessments.

Recommendation #7. The National Council of Welfare reminds governments that recommendations made in previous Council reports on subjects such as taxation, employment and social assistance would also lead to better health among poor people.

5. THE SIREN CALL OF TECHNOLOGY

Health care in the twentieth century has been marked by the rapid development of new drugs, equipment, tests and techniques. While many are of great benefit, some are of little or no consequence, and others may turn out to do more harm than good.

What does technology mean for our health care system? And how can we best take advantage of innovations which are beneficial while avoiding those which are not?

One of the consequences of technological change has been to raise the cost of health care. Canadian estimates are few, but the Canadian Medical Association Task Force on the Allocation of Health Care Resources made a "best guess" in 1984 that the introduction of new technologies caused an increase of between one and three per cent of total health expenditures per year during the previous decade.[28]

New technology refers not only to the high-cost glamorous equipment and procedures such as organ transplants which capture the public's attention, but also to lower-cost technologies such as blood tests. These tests are inexpensive individually, but the total cost is high when they are used routinely.

Moderating the cost of new technology in the health care system may be accomplished by "weeding out" ineffective or inefficient developments and by allowing more effective or efficient ones to come into common usage more quickly. This process requires systematic mechanisms to evaluate a technology before it is introduced and to monitor its use afterwards.

Many Canadians may be under the impression that such mechanisms already exist. In fact, there is little systematic review of medical technology, particularly in the area of cost effectiveness. The federal government requires manufacturers of drugs and medical devices to show that their products are safe and medically effective before they are sold in Canada, but it does not have procedures for comparing the cost effectiveness of new drugs or devices to the cost effectiveness of products already on the market.

A 1986 study by McMaster University researchers Greg Stoddart and David Feeny on the state of medical technology assessment in Canada came to some startling conclusions. They found that:[29]

* Technologies are often accepted for use without evaluation.

* When evaluations are done, technologies are often put into use before the evaluations are completed.

* Technologies that have been evaluated and accepted for use are often used for conditions that were not covered by the evaluations.

* Technologies that have been evaluated, accepted, and used for their intended purposes are often utilized too much.

* Even for technologies that avoid all these problems, their value may be dubious because there is an equally effective and less costly technology that is <u>not</u> being used.

Companies that manufacture pharmaceuticals, medical devices, and medical or surgical equipment have obvious vested interests in establishing their own products in the marketplace, whether or not

they represent any real advances over existing products. Even within the medical profession, where there are no proprietary concerns, there can also be a rush to new technology before it has been properly evaluated.

A few years ago, for example, a group of Hamilton doctors was lobbying for a new lithotripsy machine to break up kidney stones with ultrasonic waves at a time when the Ontario government was still in the process of evaluating it. The Hamilton group was impatient and claimed patients were being deprived of state-of-the-art medicine.[30]

On the other hand, it was clear there were legitimate questions about lithotripsy, despite its widespread use in the United States. Two expert panels which reported in the Journal of the American Medical Association in March 1988 concluded that lithotripsy was safe and effective, but it was only one of a number of techniques available for getting rid of kidney stones.[31]

Assessing the cost and benefits of lithotripsy compared with alternative techniques was beyond the mandate of the expert panels. From the point of view of the Ontario government, however, the cost of the machines was an obvious concern. They cost about $2 million each to buy and involve significant annual operating expenses. In choosing to spend millions of dollars on these machines, Ontario would be choosing not to spend millions on something else. Thus, despite the understandable impatience of the doctors pushing for a quick decision, there was good reason to evaluate the technology carefully.

Other Western countries have long had national agencies to provide systematic, thorough and objective mechanisms for the review of technology. The Netherlands has a Commission on Future

Health Technology, Sweden has a Planning and Rationalization Institute, and the United States an Office of Health Technology Assessment.

Canada decided to follow suit in late 1989, when the federal government reached agreement with the provinces on the creation of a small non-profit corporation in Ottawa named the Co-ordinating Office for Health Technology Assessment.[32]

The mandate of the corporation is to facilitate the exchange of information on both new and existing technology, to pool financial resources as required, and to try to co-ordinate assessments that are being done by provincial agencies or researchers outside government. One of its more important jobs is to help governments avoid repeating each other's research. The technologies of concern include all procedures, devices, equipment and drugs used in the maintenance, restoration and promotion of health.

The professional staff in Ottawa will try to keep abreast of the latest developments in technology and the latest scientific literature. Their reports will be written in non-technical language and in a manner designed to help policy-makers make decisions. While their reports will be directed to governments, there appears to be a willingness to distribute the findings to health care professionals and the general public as well.

Officials say their prime concern is not to evaluate the cost effectiveness of individual items such as the latest piece of diagnostic equipment, but rather to deal with <u>areas</u> of technology so that comparisons between similar technologies can be made - for example, which drugs or surgical techniques are most useful and most cost-effective in treating certain kinds of heart conditions.

The National Council of Welfare welcomes the creation of the Co-ordinating Office for Health Technology Assessment. It is important in itself because of the work it will do. It is also important as an example of the strides forward that are possible when governments join together on projects that are clearly in the best interest of everyone.

At the same time, we have lingering concerns about the capacity of these efforts to influence the course of health technology in Canada. The office opened its doors in the summer of 1990 with a total operating budget of only $500,000 a year and a staff of only four people. The professional staff will not do evaluations of its own, only assess the work of others. Neither Ottawa nor the provinces have made standing commitments to provide money to finance external research that the staff may recommend.

The two levels of government have agreed to evaluate the usefulness of the corporation before its third birthday. We hope that it lives up to expectations. If it does not, we trust that governments will increase its resources so it can have a positive impact on health technology.

<u>Recommendation #8</u>. The National Council of Welfare commends the federal and provincial governments for their joint efforts in creating the Co-ordinating Office for Health Technology Assessment. We urge the two levels of government to ensure there is sufficient staff and money so it can have a major impact on the evolution of health technology.

6. HEALTH AND HUMAN RESOURCES

Much of the cost of health care is made up of the cost of services provided by women and men in a variety of health care professions and occupations, from nurses and doctors to hospital workers and support staff. It makes sense to ensure that the talents of these people are not going to waste and that the services they provide are adequate and efficient.

Many of the concerns about human resources and health care have focused on doctors, but it is clear that better planning is needed in other professions as well. Periodic shortages of nurses and medical technicians have a direct effect on the number of people who can be treated in our hospitals. In July 1990, for example, the Hospital for Sick Children in Toronto decided to give nurses wage increases and bonuses of up to $9,000 a year to counter staff shortages that had closed intensive-care beds at the hospital.[33]

Finally, we need to look beyond the traditional health care professions to alternative forms of medicine. When we talk of human resource planning, we should not forget those who practice chiropractic, acupuncture, naturopathy and other alternatives which have attracted the interest of many Canadians.

The number of doctors is a key variable in the health care system, because doctors play such a pivotal role. They alone control the type of treatment patients receive - when patients are admitted to hospital, when they are discharged, what laboratory tests are done, what medications are prescribed and so on.

In the early 'sixties, there were widespread concerns that Canada was facing a shortage of doctors, and governments responded with measures that increased the supply in short order. By the 'eighties, the fear was that we would soon have too many doctors. A 1984 report prepared for the federal and provincial Deputy Ministers of Health, Physician Manpower in Canada: 1980-2000, estimated there would be a surplus of 5,982 doctors in Canada by the year 2000 at current rates of growth in the population and the profession.[34]

The report estimated that the additional cost of surplus doctors would top $600 million a year by the year 2000 in terms of billings alone. Another $600 million a year could easily be spent on laboratory tests and other procedures ordered by these doctors, bringing the total additional cost to well over $1 billion a year.

It is now becoming clear, however, that gross measures such as the overall ratio of doctors to the general population are not sufficient. Planners also have to take account of future work patterns within the profession, demographic changes, the likely incidence of diseases and disabilities and how they will be treated, the mix of general practitioners and specialists, and the geographical distribution of doctors throughout Canada.

The distribution of doctors among urban, rural and remote areas has been a particularly troublesome issue in recent years. All provincial governments have grappled with the problem with limited degrees of success.[35]

One of the more simplistic attempts - and one that was eventually struck down by the courts - was British Columbia's attempt to limit the number of doctors practicing in the Lower

Mainland by putting limits on the "billing numbers" that doctors need to get paid by the province's medicare plan.

One of the more promising approaches has evolved over the years in Quebec. Quebec started out using doctors' fees as both a carrot and a stick. Doctors got up to 120 percent of the normal fee schedule during their first three years of practice if they worked in remote areas and only 70 percent of the schedule if they located in urban areas. A more comprehensive approach was adopted beginning in 1984 that included improving health institutions in remote areas and better continuing education programs for doctors. This was followed by legislation to require regional health planning.

Although these developments have yet to be thoroughly evaluated, the Canadian Medical Association has endorsed the general idea of tackling planning from the bottom up as well as from the top down. As the CMA Committee on Physician Resources put it:

> Planning for tertiary care services in downtown Toronto does not bear much in common with planning for services for a small town in British Columbia, for Prince Edward Island, for Quebec's North Shore or for the Inuit in the Canadian Arctic. We therefore propose that all provinces and territories see that each of their regions prepares a regional physician resource plan.[36]

While human resource planning seems to be getting more sophisticated as far as doctors are concerned, the same cannot be said in the field of nursing. Every few years, it seems, there are shortages of nurses followed by surpluses followed by shortages once again.

The Canadian Nurses Association sees shortages largely as a result of poor working conditions within the profession. In effect, the problem is not a shortage of nurses in the absolute sense, merely a shortage of nurses who are willing to work under prevailing conditions.[37]

Common complaints of nurses include lack of adequate staffing in hospitals, too many non-nursing duties, lack of involvement in decision-making, lack of educational opportunities, and inflexible work schedules, not to mention obvious concerns such as salaries and benefits.

Many of these problems may sound far afield of human resource planning, but they are not. It is one thing for governments to provide money, teaching staff and facilities to train a certain number of nurses in different parts of the country each year. It is another thing to ensure that working conditions are favorable enough to keep most of them on the job after graduation year after year.

There have been dozens of studies about human resources and nursing in the last few years. We believe the time has come for governments to act to break the recurring cycle of shortages and surpluses. In particular, governments have to make sure that people trained in nursing do not walk away from their chosen profession. Their departure is a loss in itself, and it also undermines the best efforts of planners to come up with rational ways of meeting the human resource needs of the entire health care system.

Recommendation #9. **The National Council of Welfare urges governments at all levels to work more closely with each other and the health care professions on Canada's human resource needs in health care. Governments should concern themselves with better working conditions and do whatever else is necessary to encourage trained professionals to continue practicing in their chosen fields.**

7. STIMULATING INNOVATION

Innovation in the delivery of health care services, as opposed to innovation in medicine, is far from commonplace in Canada. There have been relatively few attempts to find better or more cost-effective means of delivering services. Those experiments that do take place are often done in isolation or are poorly evaluated.

"Innovations in delivery patterns that are cost-effective and efficient and more appropriate to today's illness patterns concern us all and are urgently required," says the Canadian Nurses Association.[38]

Much of the rigidity in our system stems from the way medicare came into being, as a payment mechanism for existing services. Medicare effectively "locked in" established patterns of delivering health care. As a result, changes in the delivery system are unlikely to happen on their own.

We believe there should be several major innovative projects under way in Canada at any given time as a sign of a "healthy" health care system. The payoffs from these experiments would appear in the long run, well beyond the mandate of any government, but the costs of conducting the experiments and evaluating them would have to be met in the short run.

Fortunately, governments have not closed the door to innovation simply because of short-term costs. In a report to the First Ministers' economic conference in 1987, provincial and territorial Ministers of Health recognized the need for more innovation and the price that would have to be paid.[39]

Unfortunately, provincial governments still seem intent on going ahead on their own in isolation from each other. More and more provinces are starting to put big money into research aimed at improving the delivery of services within their own boundaries. Manitoba, for example, is channelling $10 million a year in lottery revenues into its Health Services Development Fund to improve the efficiency and affordability of the province's health care system. It remains to be seen whether much of that research will be useful to other provinces or whether the research will eventually be duplicated by other provinces.

The same could be said of the interest in Canadianized versions of Health Maintenance Organizations. HMOs offer medical and hospital services to their members at a fixed, prepaid cost for each member. Most U.S. plans cover hospitalization costs with no additional user fees for patients, and they cover visits to the doctor with no limit on the number of appointments.

HMOs tend to use hospital services for their members more judiciously, and the result is substantial reductions in the cost of care. They also tend to practice more preventive medicare than fee-for-service doctors.

Quebec has laid the groundwork for introducing HMOs on an experimental basis and is presumably prepared to expand them to a number of areas of the province if all goes well. Ontario has announced plans for another HMO variation which it calls a Comprehensive Health Organization. The first pilot project at the Toronto Hospital is scheduled to begin in 1991, and a number of similar projects at other locations are also in the works.

It would be nice to believe that Canada's two largest provinces are not simply duplicating each other's research.

It would also be nice to believe that the experiences of the two provinces with HMOs would answer some of the lingering questions about their general adaptability to the Canadian health care scene, and that the results of the experiments would help other provinces which decide to follow in their footsteps.

However, there are no guarantees that any of these hopes will become reality as long as provinces follow their own individual paths to innovation.

Our suggestion is for the federal and provincial governments to join together and establish an innovations fund for experiments that show potential beyond the boundaries of one or two provinces. The governments would select pilot projects and decide which provinces would conduct them. All or part of the cost of the projects and all the evaluation costs would come from the innovations fund.

Federal involvement would help ensure good evaluation and experiments that are designed to be relevant to more than one province, yet it would not rule out provinces continuing to go it alone on projects with more local than national potential.

Recommendation #10. The National Council of Welfare urges the federal and provincial governments to establish an innovations fund to support research into better and more cost-effective ways of delivering health care services across Canada.

8. BETTER INFORMATION

Developing a better health care system requires better information. We need better ways of maintaining individual records so the people who use health services get the best possible care. We also need better information on the system as a whole so we can measure the impact of improvements as they are put into place.

One of the most intriguing projects in the field of health care information involves the use of computer technology to maintain and back up individual patient records. There seems to be little doubt that the medicare cards people now carry in their wallets or pocketbooks will one day be replaced with high-tech cards known as "smart cards."

Smart cards contain a microchip capable of holding a person's lifetime medical history, including records of visits to the doctor and hospital and prescriptions for medication. All the information would be backed up on a central computer system. Doctors, hospitals and pharmacists would have personal computers with special software to read the information on the cards and to enter new information.

Needless to say, great care would be taken to make sure the information on the cards is confidential. Only those health care professionals involved in a patient's treatment would have access to his or her medical history.

From the point of view of patients, the benefits of smart cards are obvious. Take the case of a man who has a stroke, is

taken to hospital by ambulance and arrives unconscious. With a smart card, the doctor on duty in the emergency room would know in an instant if the patient had previous cardiovascular problems, what medications he was taking, and whether he had allergies that could affect his treatment.

Smart cards could help health care professionals detect and treat people who inadvertently overuse prescription drugs or have adverse reactions because of the combination of medications they are taking. They could curb abuses by people who seek treatment from more than one doctor at a time. They could improve the administration of medicare billings. And they could provide a wealth of data for medical researchers, provided individual identities were properly masked.

Several provinces are doing pilot projects on smart cards at the present time. The technology itself does not appear to be a problem, but it remains to be seen whether the cost of the cards and the additional computer hardware and software needed for a new system are reasonably cost-effective.

We wish the provinces well in their experiments and look forward to the day when smart cards come into general use in Canada. At the same time, we urge governments to work together so their systems turn out to be compatible with each other. It is in the best interests of governments and patients alike to have smart cards that could be used anywhere in Canada.

Two other areas of health information need to be addressed by governments and planners at an early date. One is the information collected by provincial medicare plans. The other involves

statistics on health and health care that are collected by the federal government and, to a lesser extent, by provincial governments.

Within medicare, there is a great deal of information being collected, but little in a way that allows it to be compiled on a national basis and used for planning and research. All provinces have records of visits to the doctor or the hospital from their medicare plans, but most are limited to the minimum needed to process payments.

Where provincial data collection has been modernized, the data can be used to simulate treatment experiments with computer technology which would otherwise be prohibitively expensive or not allowed for ethical reasons. For example, a researcher can compare a sample of the population which used a particular service with a sample of the population which did not. Without any interference in anyone's privacy, the impact of the service can be assessed.

Confidentiality is an important consideration, but this seems to go hand in hand with modernization. In fact, there has never been an electronic data base "leak" or even the hint of one in any of the provinces which have modernized their data collection systems.

At the present time, there is only limited work being done on developing systems which are compatible among provinces. The ability to link data bases would allow better planning of health services requirements nationally and raise the research potential enormously. It will no doubt be demanded in the twenty-first century, but the cost and the length of time it will take could be greatly reduced if governments began now.

Along similar lines, we are pleased to note improvements that have already been made within Canadian hospitals. The Management Information Systems Project started in 1981 by the federal and provincial Ministers of Health and the Canadian Hospital Association has led to standardized reporting in many hospitals.[40]

In the spring of 1990, the project merged with the National Hospital Productivity Improvement Program to form a non-profit corporation known as the MIS Group. The goals of the new corporation are to improve the timeliness, usefulness and comparability of data being collected within the health care industry and to provide reliable measures of inputs and outputs.

Finally, in the field of health and health care statistics, the federal and provincial governments also seem to be making progress. After several years of discussion, the Conference of Deputy Ministers of Health agreed in late 1988 to set up a National Health Information Council reporting directly to them and to the Chief Statistician of Statistics Canada. The Council, composed of senior officials from both levels of government, will try to bring a much-needed national perspective to the field.[41]

There are several federal agencies collecting information - especially Statistics Canada and Health and Welfare Canada - and provincial governments and agencies outside government also gather health statistics. The National Health Information Council offers a way of co-ordinating these efforts, avoiding unnecessary duplication, and promoting information systems that are compatible from one province to another. Hopefully, it will also have time to think about the value of some of the data-collecting activities of government and whether some particular exercises should be discontinued altogether.

Recommendation #11. The National Council of Welfare commends the federal and provincial governments and professional organizations in the health care field for their support of new information systems that are compatible across the country. We look forward to continued progress in the development of "smart cards" and in modernizing the data bases of provincial medicare programs.

9. NO-FAULT COMPENSATION

Serious injuries and deaths inevitably occur from time to time as a result of medical and surgical procedures. When they do, the traditional recourse has been for the injured party to sue for malpractice or negligence.

However, some injuries occur without any malpractice or negligence. In these cases, it makes sense to compensate victims under a "no-fault" government assistance plan rather than force victims to go to court and seek damages from individual doctors or hospitals.

The federal government has already accepted the general idea of no-fault compensation. In December 1989, it announced an assistance plan for people who contracted the AIDS virus from blood transfusions or Factor VIII, a concentrated clotting agent extracted from blood and used in the treatment of hemophilia. Although the settlement was officially described as "disaster relief," it has all the features of no-fault assistance.

Blood donors were not routinely tested for exposure to AIDS before 1985, partly because the tests were not available and partly because the extent of the risk of AIDS was not fully known. Once the danger became clear, the Canadian Red Cross Society quickly intervened to ensure that blood contaminated with the AIDS virus was not used. But no one was at fault for the earlier mishaps.

Under the federal government plan, about 950 people who were infected with the AIDS virus from Factor VIII and about 300 people infected through blood transfusions got $120,000 each. The money

went to people infected with the AIDS virus as well as those who had already developed full-fledged cases of AIDS. For victims who had died, the money went to their estates.

In our view, a second group that deserves no-fault assistance from the federal government is the estimated 5,000 children who suffered serious injuries or died from vaccines used in routine immunizations, especially certain types of whooping cough vaccine.

Many provincial governments require children to be immunized as part of society's overall fight against disease. Unfortunately, there are risks associated with immunization, and a very small number of children who are immunized have adverse effects. These effects can hardly be considered the result of negligence or malpractice.

As in the case of people infected with the AIDS virus from blood transfusions or Factor VIII, the issue for immunization victims is help rather than legal revenge. The federal government has not raised any objections in principle, but it has avoided taking any action since parents of immunization victims first raised the issue several years ago. We believe the time for action is now.

In cases of avoidable rather than unavoidable accidents, further moves in the direction of no-fault compensation could result from the recently published Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care. The review was headed by J. Robert S. Prichard, former dean of the faculty of law at the University of Toronto and now president of the university.

The cost of liability insurance for doctors and health care institutions now exceeds $200 million a year, yet only about 250 people a year are awarded compensation under the current "fault" system. The Prichard report estimates that those 250 people represent less than ten percent of the people entitled to damages in any given year.[42]

"It is simply not good enough for us to ignore the vast majority of these victims," the report said. "If we are to be as compassionate and caring as we can and should be, we need to find ways to provide a decent level of compensation for these victims without further burdening the malpractice litigation system."

The report recommends giving victims of malpractice the option of pursuing their claims in court or seeking no-fault compensation under a new system that would be supported by government and by companies and organizations which insure doctors and health care institutions.

Continuing the option of legal action, with some improvements in the system, would provide a continuing incentive for doctors and hospitals to provide the best possible care. Providing the new option of no-fault compensation would ensure that most people receive compensation for their injuries.

The National Council of Welfare looks forward to early action on the Prichard report. This does not mean, however, that the federal government should wait to implement no-fault compensation arrangements for immunization victims as discussed earlier in this chapter.

Recommendation #12. The National Council of Welfare commends the federal government for its decision to compensate people who were accidentially infected with the AIDS virus through blood transfusions or blood products. We urge that similar "no-fault" arrangements be made as soon as possible for victims of immunization injuries.

10. OVERSEEING THE CANADA HEALTH ACT

The late 'seventies and early 'eighties heard growing complaints about the erosion of medicare because of extra billing by doctors and hospital user fees in certain regions of Canada. Supporters of medicare said these out-of-pocket charges were deterring poor people from seeking treatment and seriously compromising the principles of public health insurance.

Parliament responded in 1984 with the passage of the Canada Health Act. The Act reaffirmed and clarified the five principles of medicare: universality, accessibility, comprehensiveness, portability and public administration. It also gave the federal government explicit power to levy financial penalties against provinces and territories which failed to comply with these principles.[43]

The act provided for two types of penalties: (1) penalties related specifically to extra billing and user fees; and (2) discretionary penalties of a general nature.

Under the penalties related to extra billing and user fees, offending governments lost one dollar of their federal cash grants for medicare for every dollar they allowed to be collected from patients. Provinces and territories that got rid of out-of-pocket charges before April 1, 1987, were entitled to any money withheld prior to that date.

As a result of the dollar-for-dollar penalties, extra billing by doctors and hospital user fees all but disappeared by the spring of 1987. However, the public debate is far from over. Many doctors continue to believe that patients should pay part of the

cost of care out of their own pockets - "patient participation" is one of the euphemisms used to describe this practice.

User fees have become increasingly attractive in some political circles in Ontario and Quebec. Even Claude Castonguay, the man often described as the father of medicare in Quebec, has talked of introducing user fees into the system or turning some services over to the private sector.

On the other hand, New Brunswick had to back away from its 1988 decision to impose charges of $15 a night for out-patient beds at hostels connnected with three hospitals. The charges apparently did not violate the Canada Health Act, but the province quickly changed its mind following protests led by the New Brunswick branch of the Canadian Cancer Society.

Unlike the specific penalties for extra billing and user fees, the general penalties in the Canada Health Act were intended to apply to any province or territory that failed to live up to any of the five principles of medicare. The Act said the amount of each penalty would be set by the federal government depending on the seriousness of the violation.

There have been periodic public complaints about violations, but no federal government has imposed or even threatened to impose a general penalty on any province or territory. The most common concerns involve the principles of comprehensiveness and portability.

Comprehensiveness means that all health services provided by doctors and hospitals that are "medically necessary" must be covered by provincial and territorial medicare plans.

Most governments have been content to let doctors themselves decide what is medically necessary. Where governments intervened, they wound up backing down in the face of public opinion.

In the spring of 1987, for example, the Alberta government removed eye examinations, vasectomies, tubal ligations, and the insertion of intrauterine devices from medicare coverage in an effort to save money. The cuts prompted a public outcry, and the services were reinsured the following year.

The government of British Columbia took even less time to back away from its 1988 decision to restrict the use of mammography, an x-ray technique for early detection of breast cancer. The province now has a formal breast cancer screening program using mammography and could have as many as 20 screening centres within five years.

While problems related to the principle of comprehensiveness have been resolved reasonably quickly, the same cannot be said for a dispute involving the principle of portability and the government of Quebec.

The Canada Health Act defines portability as the provision of insured health services for people "temporarily absent" from their home province or territory. The definition is normally taken to mean that, when a medical problem arises without notice, people can receive treatment anywhere in Canada and not have to worry about paying the bill out of their own pockets. However, they still require the prior consent of their own medicare plan before travelling outside the province to obtain <u>elective</u> medical or surgical treatment.

By the spring of 1988, all provinces except Quebec had signed a medical reciprocal billing agreement guaranteeing the portability of insured services provided by doctors. Quebec recognized the principle of portability with respect to hospital services, but not with respect to doctors' fees.

The province's stand caused problems for Quebecers in the Outaouais region of western Quebec near Ottawa and to a lesser extent in eastern Quebec near the New Brunswick border communities of Campbellton and Edmunston.

An estimated 80,000 residents of western Quebec were being treated each year in Ottawa and adjacent municipalities. Some came to specialized facilities such as the Children's Hospital of Eastern Ontario or the Ottawa Heart Institute. Others came as a matter of convenience or personal preference - conditions which are <u>not</u> guaranteed by the portability provisions of the Canada Health Act.

The original problem arose because Quebec refused to pay Ontario medicare rates on behalf of its residents. The medicare fee schedule for doctors in Quebec is substantially lower than the fee schedule for doctors in Ontario.

Ottawa doctors were left with two choices. They could accept the lower Quebec rate. Or they could collect their fees directly from Quebec patients according to the Ontario fee schedule and let the patients get partial reimbursement from Quebec.

After years of sporadic negotiations, Quebec finally agreed to provide limited portability to residents of the Outaouais, effective November 1, 1989. The agreement covers Outaouais residents who need emergency medical treatment in Ottawa or

specialized treatment in Ottawa that is not available in the Outaouais. Treatments under the agreement are paid by Quebec at Ontario rates.[44]

While the agreement is better than nothing and helps ease a troublesome local problem, it is a far cry from the kind of portability envisaged by the drafters of the Canada Health Act. It does not cover Quebecers who live outside the Outaouais region, and it does not cover residents of the Outaouais who are treated outside of the National Capital Region - people on business trips or holidays in other parts of the country, for example.

The National Council of Welfare strongly believes that a public health insurance plan financed heavily by the federal government should provide portable coverage, as defined in the Canada Health Act, to all residents of Canada.

We also believe that the federal government should use the general penalty provisions of the Canada Health Act as a last resort to enforce portability or any of the other principles of medicare. Penalties may be the only way in some cases to force a province or terrritory to live up to its legal responsibilities. At the same time, the history of dollar-for-dollar penalties shows that penalties can be imposed in a way that makes governments sit up and take notice without affecting medicare services to individuals.

Recommendation #13. The federal government should be more vigilant about safeguarding the five principles of medicare: universality, accessibility, comprehensiveness, portability and public administration. It should not hesitate to use the general penalty provisions of the Canada Health Act as a last resort in resolving matters of principle.

11. THE CASE AGAINST MEDICARE PREMIUMS

The National Council of Welfare has long criticized medicare premiums as an unfair and inefficient way of raising money to help pay for health care. Premiums by their very nature are regressive and impose a heavy burden on large numbers of people with low or modest incomes. The administrative systems required to collect premiums and to reduce or eliminate charges for the poor are unnecessarily complex.

Some provinces and territories decided to avoid premiums altogether when their medicare systems first came into being. Others got rid of premiums in subsequent years and now raise the money required from income taxes or payroll taxes instead.

The only two governments that continue to levy premiums are Alberta and British Columbia, and neither government seems anxious to change. Alberta increased its premium rates as of October 1, 1990, and plans further increases over the next two years.

A closer look at Alberta and British Columbia shows how unfair premiums are to poor people - even with the premium subsidies or premium assistance available.[45]

In Alberta, medicare premiums as of October 1, 1990, are $23 a month or $276 a year for a single person and $46 a month or $552 a year for a family. There are premium subsidies that reduce the amounts for some low-income people and eliminate them entirely for the very poor. However, Albertans of modest income pay the same flat rate as millionaires.

Table 3 gives the cost of premiums for a one-earner couple with two children for the year July 1, 1989, to June 30, 1990 - before the 1990 increases took effect. The first column shows taxable income. The second column is "adjusted taxable balance," an artificial calculation that serves as the basis for premium subsidies. Adjusted taxable balance is taxable income minus five times the value of the non-refundable tax credits on income tax forms. The third column gives the amount of premiums for the 12 months after the subsidies have been deducted.

TABLE 3

ALBERTA MEDICARE PREMIUMS,
COUPLE WITH TWO CHILDREN, 1989-1990

Taxable Income	Adjusted Taxable Balance	Annual Premiums
$ 16,000	$ 5,474	$ 0
18,000	7,400	153.00
20,000	9,327	306.00
22,000	11,253	463.50
24,000	13,179	463.50
26,000	15,105	463.50
28,000	17,042	463.50

Families with adjusted taxable balances of $6,000 or less paid no premiums at all. Families with balances above $6,000 but but not more than $10,000 got partial subsidies. Those above $10,000 paid the full rate.

Because of the way the premium subsidy system was set up, there is a "notch effect" that penalizes people just over the income limits for each category of subsidy. For example, a family with an adjusted taxable balance of exactly $6,000 paid no premiums at all. A family with a balance of $6,001 got stuck with a premium bill of $153 in 1989-1990 because of that extra dollar of income.

As we said at the beginning of this chapter, the basic problem with premiums is their burden on low-income people. The family in Table 3 with taxable income of $22,000 and an adjusted balance of $11,253 was required to pay full monthly premiums. Taxable income of $22,000 is equivalent to gross income of about $24,000 - certainly well below the estimated 1990 poverty line of $28,061 for a family of four in a large city like Edmonton or Calgary.

Premiums in Alberta, and in British Columbia, are levied at the same flat rate for all provincial residents above the subsidy levels and are not related in any way to a person's ability to pay. As shown in Figure B, a one-earner couple with two children and taxable income of $22,000 paid about two percent of taxable income in medicare premiums in 1989-1990. The family with taxable income of $100,000 paid less than 1/2 of one percent.

Alberta Health Care Premiums As Percentage of Taxable Income, Couple With Two Children, 1989-1990

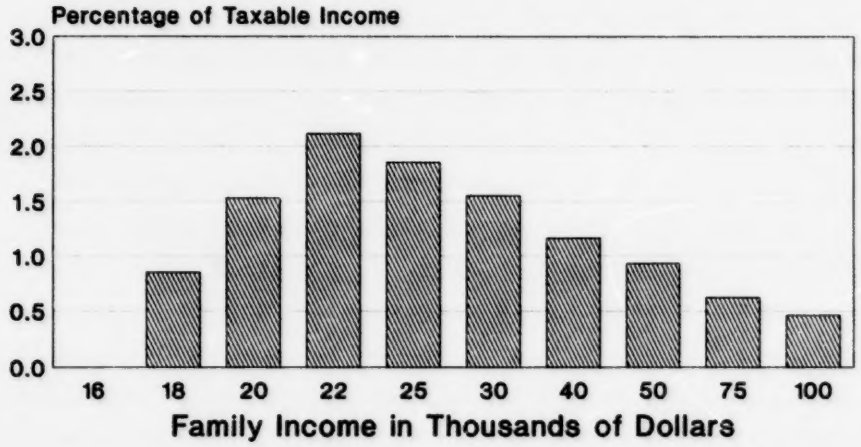


Figure B

The system of medicare premiums in British Columbia is a bit different from the Alberta system, but its flaws are similar. As of April 1, 1989, premiums amounted to $31 a month or $372 a year for a single person, $55 a month or $660 a year for a family of two, and $62 a month or $744 a year for a family of three or more.

Table 4 shows the way the premium system worked for the 12 months that began July 1, 1989. Column one shows net income on income tax forms. Column two shows adjusted net income - income minus deductions of $3,000 for a spouse and each dependent child. The last column shows the cost of premiums after the assistance was deducted.

TABLE 4

BRITISH COLUMBIA MEDICARE PREMIUMS, COUPLE WITH TWO CHILDREN, 1989-1990

Net Income	Adjusted Net Income	Annual Premiums
$ 16,000	$ 7,000	$ 37.20
18,000	9,000	37.20
20,000	11,000	186.00
22,000	13,000	334.80
24,000	15,000	483.60
26,000	17,000	632.40
28,000	19,000	744.00

The maximum assistance is 95 percent of the full premium. Even the poorest of the poor have to pay the other five percent. A single person getting 95 percent assistance pays $1.55 a month, a couple $2.75 and a family of three or more $3.10. The administrative cost of collecting these amounts each month is obviously much greater than the amounts themselves.

A person or family with adjusted net income of $9,000 or less gets 95 percent premium assistance, people with adjusted net incomes between $9,000.01 and $17,000 get lesser amounts of assistance, and people above $17,000 pay full premiums.

As in Alberta, there are notches in the premium assistance program. A family with adjusted net income of $9,000 pays $37.20

a year. A family with adjusted net income of $9,000.01 pays $186 a year because of one extra cent of income.

Figure C shows how the burden of premiums in British Columbia is distributed. Clearly, the middle classes have to bear the heaviest burdens, up to 2.5 percent of their net incomes. The family with net income of $22,000 a year and living well below the poverty line for Vancouver pays premiums equal to about 1.5 percent of net income. The richest people get away with premiums equal to one percent of net income or less.

B.C. Health Care Premiums As Percentage of Taxable Income, Couple with Two Children, 1989-1990

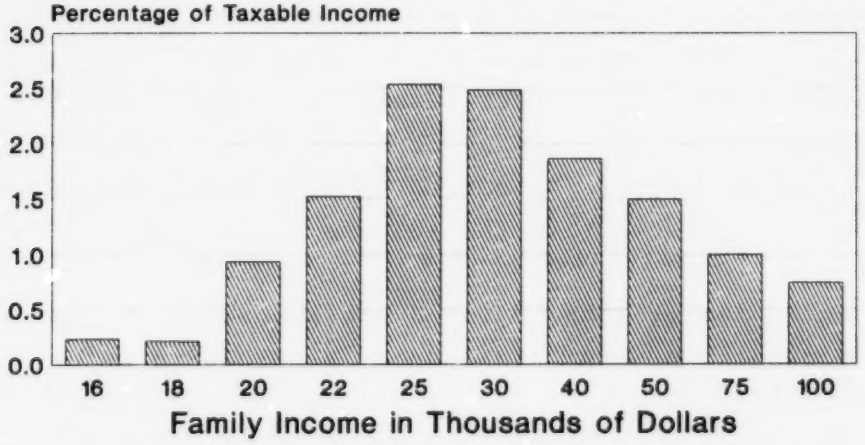


Figure C

Given all these shortcomings, we find it hard to understand why the governments of Alberta and British Columbia cling to the notion that premiums are a reasonable way of raising money for medicare - especially now that the premium system has been rejected by all other provincial and territorial governments.

In the final analysis, money for medicare comes from only one source, the taxpayer. Whatever money premiums provide for health care can be raised instead through an increase in income taxes or payroll taxes. Our first choice for raising the funds is income taxes, because the system is administratively simple, progressive, and based on taxpayers' ability to pay.

The payroll taxes used in several provinces to raise a portion of the funds for medicare are better than premiums, but less desirable than income taxes. Where payroll taxes are used, we would hope that provincial governments consider the needs of community and non-profit organizations, which may have trouble paying the new taxes without increases in the funds they receive from government.

Finally, we note in passing one of the stranger arguments that has been used in support of premiums over the years, the argument that premiums represent a "visible link" between the cost of medicare and the benefits it provides. It is difficult to believe that residents of Alberta and British Columbia who pay premiums are more conscious of the cost of health care than residents of Saskatchewan who do not.

For governments which are concerned with informing taxpayers of the cost of medicare, a far better alternative would be to give consumers copies of the bills that doctors, dentists and hospitals submit to provincial medicare plans for treatment. This is already

done in some cases in Prince Edward Island and other provinces. The statements are a tangible reminder of the cost of care, but they also remind users of medicare of the value they are getting from the taxes they pay.

Recommendation #14. The National Council of Welfare urges the governments of Alberta and British Columbia to take a serious look at premiums and their unfair impact on people of low and modest incomes.

Recommendation #15. The National Council of Welfare encourages provincial governments to inform residents of the cost of the medicare services that they personally use.

12. EXTENDING EXTENDED CARE

All the experts agree that Canada's population will continue to "age" noticeably through the first part of the twenty-first century. The portion of the population 65 and older will more than likely double during the next 35 years. Within the elderly population, more people will be living longer than ever before. Canadians 75 and older now make up just under 40 percent of the elderly population. That figure could approach 70 percent by the year 2026.[46]

Older people have long been the biggest users of extended health care such as nursing homes and home care, and the need for these services is bound to increase as the population ages. The question is whether governments will be ready to meet the need.

The National Council of Welfare believes it is in the interest of everyone to accelerate the development of extended care across Canada. It is also our belief that this will happen only with strong federal leadership and a healthy infusion of federal cash.

Current arrangements vary greatly from region to region. Extended care has been a priority in some provinces, but its development elsewhere has been modest.

Similarly, provinces have had varying degrees of success in integrating the medical and non-medical aspects of extended care. Many people who want to stay in their own homes, for example, need not only medical care but a variety of social supports to meet their non-medical needs. A comprehensive home care program would provide services such as hot meals, homemaking,

help with minor home repairs, adult day care, and respite care to give family caregivers a break every now and then.

Quebec's program of home care delivered through local health and social service centres is often used as an example of a well-designed, coordinated program, but the demand for services still seems to be far ahead of the supply.

Aside from the quantity of extended health services, there is also reason to suspect substantial problems with the quality of services. Many provinces do not enforce rigorous standards of care, and some rely upon profit-making residential facilities whose appropriateness in dealing with frail, dependent people is questionable.[47]

As we mentioned at the beginning of this report, the terms used to describe different forms of extended care make it unnecessarily difficult to collect information from province to province or even to have an intelligent discussion.

In Ontario, for example, the term "nursing home" refers to a privately run commercial operation and "home for the aged" to a non-profit operation run by a municipality or charitable or community organization. The two types of institutions appear similar to outsiders, but they are governed by different laws and have different entitlements to provincial grants.

Getting information of any kind about the range of services available is also difficult. Some provinces put only a few paragraphs about extended care in their annual departmental reports. One province which is an exception to the rule and does a superior job is Saskatchewan. Its annual reports on

long-term care and home care provide a wealth of detail about the programs and the people who make use of them.[48]

The problems of terminology and information are minor, however, compared to the financial restraints on extended care. Extended care makes financial sense over the long term because it is less expensive than hospital care. But in the short term, developing a new system will no doubt add to the cost.

A study by Woods Gordon commissioned by the Canadian Medical Association Task Force on the Allocation of Health Care Resources looked at the savings that would result from reducing the rate of institutional care of the elderly from 9.45 percent to six percent. It predicted that alternative forms of care would cut $5.9 billion from a projected increase in annual operating costs of $13.7 billion by the year 2021. The savings of $5.9 billion do not include huge savings on capital construction over a 40-year period.[49]

Using more conservative assumptions, Dr. John Horne of the University of Manitoba estimated the savings on annual operating costs at between $2.3 billion and $3.5 billion by 2021.[50]

No matter which figures are used, it is clear that there are substantial savings to be had by moving away from traditional forms of institutional care. However, they are savings in the form of reductions in future cost increases rather than savings in current expenditures. In the very difficult task of allocating funds among competing priorities - the real world in which budgets are established - most Ministers of Finance are reluctant to part with funds today in hopes of realizing savings tomorrow.

Before we propose our own way of facilitating the development of more and better extended care services, we need to look at the existing federal-provincial fiscal arrangements.

Ottawa provides funds for health care and post-secondary education under the Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act, commonly known in government circles as the Established Programs Financing (EPF) legislation. The funds includes a grant earmarked specifically for extended care. During the 1989-1990 fiscal year, the extended care grant amounted to $53.50 per capita or more than $1.3 billion for Canada as a whole.

The extended care payments are intended to cover nursing home intermediate care, adult residential care, converted mental hospitals, home care, and ambulatory health care. Under previous fiscal arrangements, all these services that were not covered by provincial medicare plans were cost-shared 50-50 by Ottawa and the provinces under the Canada Assistance Plan (CAP), but only for people in need.

When the Established Programs Financing legislation came into force in 1977, these programs were no longer cost-shareable. In other words, provinces and territories gained money for extended care under EPF, but lost money from CAP. The extent of the gains or losses varied sharply according to the availability of extended care services in each province or territory and the percentage of services used by people in need.

By the 1980-1981 fiscal year, Newfoundland, Prince Edward Island and Yukon were actually worse off financially under the new arrangements. All other jurisdictions reported net gains, with the largest gains in Ontario, Saskatchewan and Alberta.[51]

In more recent years, provinces and territories have been squeezed financially by cuts in the general EPF formula imposed on them by the federal government.

The original deal was that federal support per capita for medicare, post-secondary education and extended health care would increase each year in line with increases in the gross national product calculated as a three-year moving average.

In 1986, the EPF legislation was amended to reduce the rate of growth in federal contributions to increases in the gross national product minus two percentage points. Further reductions were announced in the 1989 and 1990 federal budget speeches. Grants are being frozen for two years at 1989-1990 levels. Beginning in 1992-1993, EPF growth will be restricted to increases in GNP less three percentage points. However, the growth rate will not fall below the rate of inflation.

The Finance Department never published detailed figures on losses resulting from the changes imposed in 1986, but estimates range from about $3.5 billion to $7 billion through 1990 depending on how the calculations are done.

For the five years beginning in 1990, the Finance Department estimates the losses at $7.4 billion. Outsiders say the losses will be considerably higher.

These cuts in federal funding represent a major setback to the provinces and territories in their efforts to maintain quality programs. Just as bad is the setback they represent for extended care. Provinces which are already having trouble coming to grips

with the two established programs, health and post-secondary education, will not be able to make many advances with new programs.

The National Council of Welfare believes that a reversal in federal policy is absolutely essential for the development of extended care arrangements adequate to the needs of our aging population and more or less consistent in all provinces and territories.

Our hope is that the two levels of government will be able to sit down and negotiate a reasonable formula for EPF transfers. Realistically, this will only happen if both sides are prepared to compromise.

The federal government will have to be prepared to rescind at least some of the financial restraints it imposed on the provinces and territories. We think it would be helpful as well for Ottawa to offer the provinces and territories certain guarantees against unilateral changes in policy in the future. The cuts imposed in the 1989 and 1990 budget speeches, for example, were done with no real consultation with provinces or territories. The two-year freeze in the 1990 budget speech was especially abrupt because it was announced barely a month before it went into effect.

In return, we believe Ottawa would be justified in requiring provinces and territories to live up to certain conditions for extended health care similar to the conditions in the Canada Health Act for medical and hospital services.

As we noted in Chapter 10, the Canada Health Act defines the principles of universality, accessibility, comprehensiveness, portability, and public administration. It has specific

provisions regarding out-of-pocket fees paid by users of medicare services. And it authorizes the federal government to withhold funds from provinces or territories which violate its provisions.

Somewhat similar conditions could be negotiated as part of a revised EPF agreement. With some give and take on both sides, the two levels of government should be able to put an end to their long-running differences and take a major step toward a nation-wide system of quality extended care to complement our existing nation-wide system of quality medical and hospital care.

Recommendation #16. The federal, provincial and territorial governments should negotiate improvements in the existing agreement on extended health care services at an early date. As part of a revised agreement, Ottawa should make available additional funds for extended care, and the provinces and territories should reciprocate by accepting conditions on the use of these funds.

Recommendation #17. In the interest of a better informed public, all governments should agree to standardized terminology for extended health care services.

CONCLUSION

Hardly a day goes by without a major item in the news media on some health issue. There are stories about the vast sums we spend as a nation in our search for better health, and whether the total is too much or too little. There are stories about new medical and surgical techniques, from the latest wonder drug for heart problems to recent experiments in genetic engineering to treat conditions caused by defective genes. There are stories of hospital beds being taken out of service, long waiting lists for elective surgery and other bottlenecks in the system.

While all these issues are worthy of public attention, they are not the issues we wanted to raise in this report. Our main concerns were issues that have been discussed by the experts for many years but remain largely unfamiliar to the general public.

More than anything else, we wanted to add our support for the view that the ultimate goal of public policy should be better health for Canadians. That means we must promote good health as well as treat ill health.

We have tried to show that good health is not exclusively the product of a good health care system. It is a result of many factors, many of them beyond the mandates of Health Departments or health care professionals.

Quebec's Council of Social Affairs made much the same point when it released its report Financement des services de santé: défis pour les années 90:

> We hear more and more of diminishing returns in the field of health. That means an extra dollar invested in health services has less impact on the improvement in the population's health and well-being than dollars invested in the past. On the other hand, some studies have shown that non-medical factors such as the level of education and income play a role equally, if not more significant for health than the availability of medical and hospital services.[52]

The link between poverty and poor health is a special concern of the National Council of Welfare, as we outlined in the early part of this report. We made the case for national health objectives as one way to focus more public attention on health and the specific measures needed to promote better health. We also endorsed "healthy public policy," an approach that would help ensure that government departments and agencies other than Departments of Health consider the likely effects of their policies on the health of Canadians.

We then looked at the health care system that has evolved over the years in Canada and pointed to problems in the system that governments have yet to tackle successfully. Two of these areas are the use and misuse of technology in modern medicine and the need for innovative ways of delivering services. We supported efforts by the federal and provincial governments to set up a national office on technology assessment, and we proposed the creation of a federal-provincial innovations fund to explore better ways of delivering services. Properly done, both these projects could have a major impact on our health care system, and neither would require a major outlay of funds.

Finally, we looked at medicare and outlined some of its shortcomings. Our chief concern is finding a way to provide continuing care for older people with chronic conditions without

putting them in expensive and sometimes impersonal institutions. Planners and politicians alike have talked for many years of the virtues of community-based programs that would allow people to stay in their own homes, but the demand for care in the community far exceeds the supply. A stronger federal presence would help stimulate the development of comprehensive services in all parts of Canada.

Canadians can take pride in their state of health and in their health care system. But pride in our past accomplishments should not blind us to the reality that significant improvements in health, in health care and in medicare all are possible if we are receptive to new ideas and are willing to challenge the conventional wisdom.

SUMMARY OF RECOMMENDATIONS

1. The federal government should resume regular surveys of the health status of Canadians with a particular view to understanding the health gap that separates rich and poor.

2. The federal government should devote more resources both inside and outside government to research on the reasons for the health gap and strategies for reducing it.

3. Governments and organizations representing native people should negotiate a solution to the long-standing jurisdictional disputes involving aboriginal people living off reserves.

4. The federal government should ensure adequate levels of funding for projects on Indian reserves to enhance the health and well-being of residents. Among other things, there should be guarantees of modern water and waste disposal systems and a wide range of health and social services.

5. The National Council of Welfare proposes the creation of a Canadian Health Council to set health objectives and monitor progress in meeting those objectives. The new council should be made up of people named by governments, the health care professions, and other groups with a special interest in health.

6. The National Council of Welfare endorses the concept of "healthy public policy" and urges all governments to make it standard practice in their policy-making. They should also consider requiring health impact assessments in much the same way that they now require environmental impact assessments.

7. The National Council of Welfare reminds governments that recommendations made in previous Council reports on subjects such as taxation, employment and social assistance would also lead to better health among poor people.

8. The National Council of Welfare commends the federal and provincial governments for their joint efforts in creating the Co-ordinating Office for Health Technology Assessment. We urge the two levels of government to ensure there is sufficient staff and money so it can have a major impact on the evolution of health technology.

9. Governments at all levels should work more closely with each other and the health care professions on Canada's human resource needs in health care. Governments should concern themselves with better working conditions and do whatever else is necessary to encourage trained professionals to continue practicing in their chosen fields.

10. The federal and provincial governments should establish an innovations fund to support research into better and more cost-effective ways of delivering health care services across Canada.

11. The National Council of Welfare commends the federal and provincial governments and professional organizations in the health care field for their support of new information systems that are compatible across the country. We look forward to continued progress in the development of "smart cards" and in modernizing the data bases of provincial medicare programs.

12. The National Council of Welfare commends the federal government for its decision to compensate people who were

accidentially infected with the AIDS virus through blood transfusions or blood products. We urge that similar "no-fault" arrangements be made as soon as possible for victims of immunization injuries.

13. The federal government should be more vigilant about safeguarding the five principles of medicare: universality, accessibility, comprehensiveness, portability and public administration. It should not hesitate to use the general penalty provisions of the Canada Health Act as a last resort in resolving matters of principle.

14. The National Council of Welfare urges the governments of Alberta and British Columbia to take a serious look at premiums and their unfair impact on people of low and modest incomes.

15. The National Council of Welfare encourages provincial governments to inform residents of the cost of the medicare services that they personally use.

16. The federal, provincial and territorial governments should negotiate improvements in the existing agreement on extended health care services at an early date. As part of a revised agreement, Ottawa should make available additional funds for extended care, and provinces and territories should reciprocate by agreeing to conditions on the use of these funds.

17. In the interest of a better informed public, all governments should agree to standardized terminology for extended health care services.

FOOTNOTES

1. The two studies used as sources for this page through Table 1 on page 8 are: Wilkins, Russell, Owen Adams and Anna Brancker, "Changes in Mortality by Income in Urban Canada from 1971 to 1986," Statistics Canada, Health Reports, Vol. 1, No. 2, March 1990, pp. 137-174; and Wigle, Donald T. and Yang Mao, Mortality by Income Level in Urban Canada (Ottawa: Health and Welfare Canada, 1980).

2. The neighborhoods were divided into five groups based on the percentage of residents living below the low income cut-offs of Statistics Canada, commonly known as the poverty lines. In the poorest neighborhoods, one of every three residents lived below the cut-offs in 1986. In the richest neighborhoods, one of every 15 residents was below the cut-offs.

3. Wolfson, Michael, Geoff Rowe, Jane F. Gentleman and Monica Tomiak, "Earnings and Death - Effects Over A Quarter Century," Research Paper Series No. 30, Analytical Studies Branch, Statistics Canada.

4. The Health of Canadians: Report of the Canada Health Survey (Ottawa: Statistics Canada and Health and Welfare Canada, 1981), p. 114.

5. The table and the information through the quote on the next page are from: Wilkins, Russell and Owen Adams, The Healthfulness of Life (Montreal: Institute for Research on Public Policy, 1983), pp. 93-99. The people in the survey were assigned to one of five groups based on their incomes, a different methodology from the one described in footnote 2.

6. This paragraph and the next three are from the Minutes of Proceedings and Evidence of the Subcommittee on Poverty of the Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women, Issue No. 2, Feb. 21, 1990, especially pp. 2-4 through 2-8.

7. Marmot, M. G, M. Kogevinas, and M. Elston, "Social-Economic Status and Disease," Annual Review of Public Health, Vol. 8, 1987, p. 129.

8. Wilkinson, Richard G., "Income and Mortality," in Class and Health (London and New York: Tavistock Publications, 1986), pp. 110-111.

9. Epp, Jake, Achieving Health for All: A Framework for Health Promotion (Ottawa: Health and Welfare Canada, 1986), p. 4.

10. Hagey, N. Janet, Gilles Larocque and Catherine McBride, "Highlights of Aboriginal Conditions 1981-2001, Part I, Demographic Trends," Indian and Northern Affairs Canada, 1989, pp. 21-22.

11. Hagey, Larocque and McBride, "Highlights of Aboriginal Conditions 1981-2001, Part II, Social Conditions," Indian and Northern Affairs Canada, 1989, p. 23.

12. Bobet, Ellen, "Indian Mortality," Canadian Social Trends, Winter 1989, pp. 12-13.

13. Avard, Denise and Louise Hanvey, The Health of Canada's Children: A CICH Profile (Ottawa: Canadian Institute of Child Health, 1989), p. 117.

14. Bobet, pp. 12-13.

15. Munro, John, Indian Conditions: A Survey (Ottawa: Indian Affairs and Northern Development, 1980), p. 144.

16. White, Pamela M., Native Women: A Statistical Overview (Ottawa: Secretary of State, 1985), p. 22.

17. Munro, pp. 30-33.

18. See U.S. Department of Health and Human Services, Promoting Health/Preventing Disease: Objectives for the Nation (Washington, 1980) and the 1986 update The 1990 Health Objectives for the Nation: A Midcourse Review.

19. Promoting Health/Preventing Disease: Objectives for the Nation, pp. 5-7.

20. The English translation of the Report of the Task Force on Health Promotion is entitled Objective: A Health Concept for Quebec, Mercedes Sandra Gayk, trans. (Ottawa: Canadian Hospital Association, 1986).

21. Health for All Ontario, Report of the Panel on Health Goals for Ontario (August 1987).

22. See "Directional Paper of the National Program to Reduce Tobacco Use in Canada" (June 1987).

23. Lalonde, Marc, A New Perspective on the Health of Canadians (Ottawa: Health and Welfare Canada, 1974), p. 18.

24. Epp, p. 10 (see footnote 9).

25. Ontario Social Assistance Review Committee, Transitions (Toronto: Queen's Printer for Ontario, 1988), p. 99.

26. Rachlis, Michael M. and Carol Kushner, Second Opinion (Toronto: Collins Publishers, 1989), pp. 308-325.

27. Information for the rest of this chapter comes from In Trouble, A Way Out: A Report on Pregnancy and Sexually Transmitted Diseases in Alberta Teens (Calgary: Calgary Health Services, 1987).

28. Task Force on the Allocation of Health Care Resources, Health: A Need for Redirection (Ottawa: Canadian Medical Association, 1984) p. 58.

29. Stoddart, Greg and David Feeny, "Policy Options for Health Care Technology" in Health Care Technology: Effectiveness, Efficiency and Public Policy (Montreal: Institute for Research on Public Policy, 1986), p. 225.

30. "Ontario Rationing Kidney Treatment Doctors Charge," Toronto Star, July 28, 1988, p. 1.

31. Journal of the American Medical Association, March 4, 1988, pp. 1382-1384, and March 11, 1988, pp. 1557-1559.

32. Information about the Co-ordinating Office for Health Technology Assessment was provided by Health and Welfare Canada.

33. "Hospital to Offer Bonuses to Hold, Lure Nursing Staff," Toronto Globe and Mail, July 5, 1990, p. 1.

34. Physician Manpower in Canada: 1980-2000, Report of the Federal, Provincial, Territorial Committee on Health Manpower (Mimeograph, 1984), p. 13.

35. Canadian Physician Resources, Report of the Canadian Medical Association Committee on Physician Resources (August 1989), pp. 29-31.

36. Same as previous, p. 46.

37. Canadian Nurses Association, Submission to the Senate Standing Committee on Social Affairs, Science and Technology (January 1990), pp. 14-16.

38. Same as previous, p. 7.

39. Provincial/Territorial Ministers of Health, Future Directions for Health Care Services (Toronto, 1987), p. 9.

40. Information for this section was supplied by The MIS Group.

41. Information about the Council and its work was published in Statistics Canada's Overview, Vol. 1, No. 2, Summer 1989. Additional information was supplied by federal officials.

42. Prichard, J. Robert S., Liability and Compensation in Health Care, A Report to the Conference of Deputy Ministers of Health of the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care (Toronto: University of Toronto Press, 1990), pp. 1-9.

43. Much of this chapter was written using the text of the Canada Health Act and press clippings.

44. The text of the agreement was supplied by the Conseil régional de la santé et des services sociaux de l'Outaouais.

45. Information about premiums and premium assistance was supplied by the governments of Alberta and British Columbia. The National Council of Welfare used the information to do the calculations for Tables 3 and 4 and Figures B and C.

46. Aging with Limited Health Resources: Proceedings of a Colloquium on Health Care (Ottawa: Ministry of Supply and Services, 1986), p. 191.

47. The report of the Task Force on the Allocation of Health Care Resources (see footnote 28) contains some particularly poignant complaints about care in some nursing homes.

48. See Saskatchewan Home Care Statistical Report or Statistical Report on Long-Term Care in Special-Care Homes and Hospitals, published by the Continuing Care Division of the Saskatchewan Health Department.

49. Task Force on the Allocation of Health Care Resources, p. 28.

50. Aging with Limited Health Resources, pp. 72-74 (see footnote 46).

51. Fiscal Federalism in Canada, Report of the Parliamentary Task Force on Federal-Provincial Fiscal Arrangements (Ottawa: Ministry of Supply and Services, 1981), pp. 117-118.

52. From "Bilan et Perspectives," issued by the Conseil des affaires sociales to announce publication of Financement des services de santé: défis pour les années 90 (Quebec: Government of Quebec, 1990).

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NATIONAL COUNCIL OF WELFARE

The National Council of Welfare was established by the Government Organization Act, 1969 as a citizens' advisory body to the Minister of National Health and Welfare. Its mandate is to advise the Minister on matters pertaining to welfare.

The Council consists of 21 members, drawn from across Canada and appointed by the Governor-in-Council. All are private citizens and serve in their personal capacities rather than as representatives of organizations or agencies. The membership of the Council has included past and present welfare recipients, public housing tenants and other low-income citizens, as well as lawyers, professors, social workers and others involved in voluntary service associations, private welfare agencies, and social work education.

Reports by the National Council of Welfare deal with a wide range of issues on poverty and social policy in Canada, including: income security programs, medicare, poverty lines and poverty statistics, the retirement income system, the aged, tax reform, the working poor, children in poverty, community economic development, women and poverty, employment policy, single-parent families, social services, nutrition, community organizing, child welfare, poor people's groups, legal aid/legal services, low-income consumers, poverty coverage in the press and welfare reform.

On peut se procurer des exemplaires en français de toutes les publications du Conseil national du bien-être social, en s'adressant au Conseil national du bien-être social, Immeuble Brooke Claxton
OTTAWA K1A 0K9